



EAR NOSE & THROAT SPECIALTIES P.C.

LIABILITY INFORMATION REPORT

Date of Injury _____

Insurance Carrier _____ Policy Holder _____

Insurance Address _____

Phone Number _____ Claim/File Number _____

Contact Person _____ Phone Number _____

PATIENT'S AUTHORIZATION

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY LIABILITY CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

I authorize release of all medical information pertinent to my medical care and necessary to process my liability claims. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to **Ear, Nose & Throat Specialties, P.C.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. If your claims are not resolved in a reasonable amount of time, you will be held responsible for payment of such claims.

I HAVE READ THIS INFORMATION THOROUGHLY AND UNDERSTAND IT.

PATIENT _____

DATE _____